

# STATEMENT FOR CRIME VICTIM MISC SVCS

Dept of Labor & Industries  
CVC Program  
PO Box 44520  
Olympia WA 98504-4520


☐ Dental Services ☐ Glasses  
☐ Medical Equipment/ ☐ Vocational/  
Prosthetics-Orthotics Retraining  
☐ Transportation ☐ Other  
☐ Home Health/  
Nursing Home Services

DO NOT  
WRITE IN >  
SPACE

CLAIMANT'S NAME IN FULL First		Social Security Number (for ID only)	Claim Number
Last		Date of Birth	Date of Injury
Address		Reimburse Claimant <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount Paid \$
City	State	Name of referring physician or other source	
		Referring physician provider number	

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (use ICD-9-CM, DSM III or DSM IV). Designate left or right when applicable. 1. 2. 3. 4. 5.	For glasses, advise if old Rx was available? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>REFUND CERTIFICATION</b> I hereby certify under penalty of perjury that this is a true and correct claim for the necessary expenses incurred by me, that the claim is just and due and that no payment has been received by me on account thereof. CLAIMANT'S SIGNATURE:
	Give hospitalization dates for inpatient services Admitted ____ / ____ / ____ Discharged ____ / ____ / ____	

FROM DATE OF SERVICE	P O S	* T O S	PROC CODE	MOD CODE	Describe procedures, medical services, or supplies furnished. Attach lab reports, X-ray findings and any special services.	Dental Tooth Number	Home Nursing		GLASSES				CHARGES \$           ¢	Unit	TO DATE OF SERVICE
							No of hrs/day	Hourly/ Day rate	OLD RX OD    OS		NEW RX OD    OS				
1.															
2.															
3.															
4.															
5.															
6.															
7.															

Submission of this bill certifies the material furnished, service provided, expense incurred, or other item of indebtedness as charged in the foregoing bill is a true and correct charge against the state of Washington and that the claim is just and due.  Signature: _____ Bill date: ____ / ____ / ____	Provider or Supplier name	Provider number	Total Charge		
	Address		Phone Number		
	City	State	ZIP +		Your Patient's Account Number
	Federal tax ID number		<input type="checkbox"/> EIN <input type="checkbox"/> SSN		

Amount paid by Primary Insurance \$	Name of Primary Insurance Company	PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS OR YOUR BILL MAY BE DENIED.
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## INSTRUCTIONS FOR COMPLETING CRIME VICTIMS MISCELLANEOUS SERVICES FORM

1. Place an "X" in the box next to the type of service for which you are billing.
2. **CLAIM NUMBER:** For the claimant receiving services. Billings cannot be processed without the claim number. Crime victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC, VH, VJ or VK".

Send bills for Crime Victims claims to:  
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3. **CLAIMANT'S NAME:** Claimant's full name, last name first.
4. **SOCIAL SECURITY NUMBER:** Record claimant's social security number. It is helpful when the claim number is wrong and the claimant's name is common.
5. **ADDRESS:** The claimant's most current address.
6. **DATE OF BIRTH:** Enter the claimant's date of birth.
7. **DATE OF INJURY:** This is important and must be included. One claimant may have several claims so it is vital the proper claim be identified and charged for services provided. The date of injury positively identifies each claim.
8. **NAME OF REFERRING PHYSICIAN:** The name of the physician who has referred the claimant to you, the provider, for services. (Not applicable for Vocational Services billing.)
9. **REFERRING PHYSICIAN PROVIDER NUMBER:** The Crime Victims Compensation Program provider account number of the referring physician. The number may be obtained from the referring physician. (Not applicable for Vocational Services billing.)
10. **DIAGNOSIS:** Indicate both the ICD9-CM, DSM III or DSM IV number and the narrative diagnosis for all conditions treated. Designate left or right side of body, when applicable. The diagnosis presented must be specific. (Not applicable for Vocational Services billing.)
11. **FOR GLASSES:** Indicate by placing an "X" in the appropriate box.
12. **SERVICES RELATED TO HOSPITALIZATION:** If claimant was hospitalized, record the date admitted and the date discharged.
13. **ITEMIZATION OF SERVICES AND CHARGES:**
  - A. **DATE(s) OF SERVICE:** Record the date for each service provided. For consecutive dates of service, (e.g., home care, attendant care, equipment rental, etc.) record both beginning (from-date-of-service column) and ending (to-date-of-service column) dates.
  - B. **PLACE OF SERVICE:** Place of Service (POS) codes are printed below. Please refer to that list and place the appropriate code in the space provided.
  - C. **TYPE OF SERVICE:** A complete list of Type of Service (TOS) codes is printed below. Please refer to that list and place the appropriate code in the space provided.
  - D. **PROCEDURE CODE:** Identifies the procedures used. Procedure codes can be found in the **Medical Aid Rules and Maximum Fee Schedule** distributed by the Department of Labor and Industries.
  - E. **CODE MODIFIER:** A modifier provides the means by which the reporting physician can indicate that a performed service or procedure has been altered by some specific circumstance, but has not changed in its definition or code. When applicable, the modifying circumstance should be identified by the addition of the appropriate "modifier code number" (including the hyphen) after the usual procedure number.
  - F. **DENTAL:** To be used for dental services only.  
**Tooth Number:** Identify dental services provided by placing the specific tooth number in the appropriate box.
  - G. **HOME NURSING:** To be used for home care only.  
**Number of Hours or Days:** Identify the number of hours or the number of days that the home care services were provided.  
**Hourly or Daily Rate:** Record the rate charged (by the hour or day) for the home care services provided.
  - H. **GLASSES:** To be used for glasses repair or replacement only.  
Old Rx (OD and OS): If the old prescription is available, specify for both the left and right eyes.  
New Rx (OD and OS): Specify the new prescription for both the left and right eyes.
  - I. **CHARGES:** Charges for services provided.
  - J. **UNIT:** The sum total of services provided for days, units, or miles, etc.
14. **PROVIDER'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER:** The provider's or supplier's name and current address. If any of the information changes, notify CVC Provider Accounts immediately. (Indicating a new address on the bill **will not** change the CVC's record of address for the provider.)
15. **PROVIDER NUMBER:** Identification number designated by the Crime Victims Compensation Program for the provider.
16. **TOTAL CHARGE:** Total of all charges for services provided.
17. **YOUR PATIENT'S ACCOUNT NUMBER:** The number used to identify your patient's account.
18. **FEDERAL TAX IDENTIFICATION NUMBER:** Enter provider's IRS (Internal Revenue Service) federal tax identification number. Indicate by marking box whether federal tax ID number is EIN or SSN.
19. **AMOUNT PAID BY PRIMARY INSURANCE:** As Crime Victims Compensation is a secondary insurer, private or public insurance must be billed first. Enter amount paid by private or public insurance. Attach a copy of the explanation of benefits for payments and denials.
20. **NAME OF PRIMARY INSURANCE COMPANY:** Enter name of private or public insurance company making payments on behalf of the claimant.

### ATTACHMENTS

The following attachments **must be** submitted with billings for appropriate services:

- |                   |                      |                             |                                       |
|-------------------|----------------------|-----------------------------|---------------------------------------|
| 1. X-ray findings | 3. Office notes      | 5. Emergency Room reports   | 7. Cost invoice of supplies furnished |
| 2. Lab reports    | 4. Operative reports | 6. Diagnostic Study reports | 8. Consultation reports               |

Each attachment must have the corresponding claim number listed in the upper right corner of the attachment.

### DUE TO THE FACT THAT THE CRIME VICTIMS' BILL RECORDS ARE KEPT ON MICROFILM, BILLS AND ATTACHMENTS MUST BE LEGIBLE AND CLEAR.

The following attachment is **not** acceptable: Office Visit Slips.

### REBILLS

If you do not receive payment or notification from the department within one hundred twenty (120) days, services may be rebilled. Rebills should be identical to the original bill: same charges, codes and billing dates. Please indicate "**Rebill**" on the bill.

PLACE OF SERVICE (POS)		
03 School	11 Office	34 Hospice
04 Homeless Shelter	12 Patient's Home	41 Ambulance - Land
05 Indian Health Service	21 Inpatient Hospital	42 Ambulance - Air or Water
Free-standing Facility	22 Outpatient Hospital	50 Federally Qualified Hlth Ctr
06 Indian health service	23 Emergency Room - Hospital	51 Inpatient Psychiatric Facility
Provider-based Facility	24 Ambulatory Surgical Center	52 Psychiatric Facility Partial Hospitalization
07 Tribal 638	25 Birthing Center	53 Community Mental Health Ctr
Free-standing Facility	26 Military Treatment Facility	54 Intermediate Care Facility/Mentally Retarded
08 Tribal 638	31 Skilled Nursing Facility	55 Residential Substance Abuse Trmt Facility
Provider-based Facility	32 Nursing Facility	56 Psychiatric Residential Trmt Ctr
	33 Custodial Care Facility	60 Mass Immunization Center

### TYPE OF SERVICE (TOS)

C Chiropractic Services	P Physical Therapy
D Drugless Therapeutics	V Vocational Services
I Inpatient	3 Medical Services
M Mental Health Counselors	4 Dental
N Nurse Practitioner Services	9 Ancillary Services (attendant, equipment, glasses)
O Outpatient	
61 Comprehensive Inpatient Rehabilitation Facility	
62 Comprehensive Outpatient Rehabilitation Facility	
65 End Stage Renal Disease Trmt Facility	
71 State or Local Public Health Clinic	
72 Rural Hlth Clinic	
81 Independent Laboratory	
99 Other Unlisted Facility	